FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044057

Facility Name: SALEM VILLAGE NURSING & REHAB. CENTER, LLC

Address: 1314 Rowell (Number) Joliet (City) 60433 (Zip Code)

County: Will

Telephone Number: (815) 727-5451 **Fax #** (815) 727-9413

IDPA ID Number: 43-1823694-001

Date of Initial License for Current Owners: 8/31/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) Edward N. Slack
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,692	1
2		Skilled Pediatric (SNF/PED)			2
3	204	Intermediate (ICF)	204	74,664	3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,196	5
6		ICF/DD 16 or Less			6
7	272	TOTALS	272	99,552	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,624	333	9,584	12,541	8
9	SNF/PED					9
10	ICF	44,647	20,924	944	66,515	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,271	21,257	10,528	79,056	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.41%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/31/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 9,569

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. C # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	356,933	26,865	16,533	400,331		400,331		400,331			1
2	Food Purchase		342,453		342,453	(5,161)	337,292	(911)	336,381			2
3	Housekeeping	288,915	78,308		367,223		367,223		367,223			3
4	Laundry	108,103	26,799		134,902		134,902		134,902			4
5	Heat and Other Utilities			186,352	186,352		186,352		186,352			5
6	Maintenance	155,316		123,491	278,807		278,807		278,807			6
7	Other (specify):*											7
8	**TOTAL General Services**	909,267	474,425	326,376	1,710,068	(5,161)	1,704,907	(911)	1,703,996			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	3,080,028	502,451	67,625	3,650,104		3,650,104	27,419	3,677,523			10
10a	Therapy	116,343	37,781	24,046	178,170		178,170		178,170			10a
11	Activities	205,822	17,276	4,891	227,989		227,989		227,989			11
12	Social Services	173,066	3,375	12,157	188,598		188,598		188,598			12
13	Nurse Aide Training											13
14	Program Transportation			11,000	11,000		11,000		11,000			14
15	Other (specify):*							3,180	3,180			15
16	**TOTAL Health Care and Programs**	3,575,259	560,883	149,719	4,285,861		4,285,861	30,599	4,316,460			16
	C. General Administration											
17	Administrative	107,593		364,014	471,607		471,607	(112,428)	359,179			17
18	Directors Fees											18
19	Professional Services			90,131	90,131		90,131	6,783	96,914			19
20	Dues, Fees, Subscriptions & Promotions			26,715	26,715		26,715	(13,113)	13,602			20
21	Clerical & General Office Expenses	170,084	6,568	403,451	580,103		580,103	(24,564)	555,539			21
22	Employee Benefits & Payroll Taxes			753,980	753,980	5,161	759,141		759,141			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,532	5,532		5,532	573	6,105			24
25	Other Admin. Staff Transportation			1,910	1,910		1,910	9,449	11,359			25
26	Insurance-Prop.Liab.Malpractice							1,615	1,615			26
27	Other (specify):*							20,652	20,652			27
28	**TOTAL General Administration**	277,677	6,568	1,645,733	1,929,978	5,161	1,935,139	(111,033)	1,824,106			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,762,203	1,041,876	2,121,828	7,925,907		7,925,907	(81,345)	7,844,562			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SALEM VILLAGE NURSING & REHAB. CENTER, LLC
0044057
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	5,161	
2	FOOD		5,161

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC #0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			119,500	119,500		119,500	421,352	540,852			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,370	49,370		49,370	532,492	581,862			32
33	Real Estate Taxes			120,000	120,000		120,000	(544)	119,456			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,066,445)	13,555			34
35	Rent-Equipment & Vehicles			38,719	38,719		38,719	391	39,110			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,407,589	1,407,589		1,407,589	(112,754)	1,294,835			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		378,260	505,480	883,740		883,740		883,740			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			146,933	146,933		146,933	(900)	146,033			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		378,260	652,413	1,030,673		1,030,673	(900)	1,029,773			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,762,203	1,420,136	4,181,830	10,364,169		10,364,169	(194,999)	10,169,170			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LL # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	30,689	30		9
10	Interest and Other Investment Income	(25,962)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(911)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(146,466)	21		24
25	Fund Raising, Advertising and Promotional	(13,167)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(756)	20		28
29	Other-Attach Schedule	(24,648)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,221)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(13,778)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,778)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (194,999)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SALEM VILLAGE NURSING & REHAB. CENTER, LLC

ID# 0044057

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Out of Period Legal Fees	(4,811)	19	2
3	Bank Charges	(3,064)	21	3
4	Auto Rental	(14,343)	35	4
5	Excess Bed Tax	(900)	42	5
6	Bank Charges-Bldg Partnership	(625)	21	6
7	Replacement Taxes-Bldg Partnership	(361)	21	7
8	Non-care Real Estate Tax	(544)	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(24,648)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(911)											(911)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	**TOTAL General Services**	(911)											(911)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			27,419									27,419	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,180									3,180	15
16	**TOTAL Health Care and Programs**			30,599									30,599	16
	C. General Administration													
17	Administrative			(112,428)									(112,428)	17
18	Directors Fees													18
19	Professional Services	(4,811)		11,594									6,783	19
20	Fees, Subscriptions & Promotions	(13,923)		810									(13,113)	20
21	Clerical & General Office Expenses	(150,516)	986	124,966									(24,564)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			573									573	24
25	Other Admin. Staff Transportation			9,449									9,449	25
26	Insurance-Prop.Liab.Malpractice			1,615									1,615	26
27	Other (specify):*			20,652									20,652	27
28	**TOTAL General Administration**	(169,250)	986	57,231									(111,033)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(170,161)	986	87,830									(81,345)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	30,689	388,458	2,205									421,352	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,962)	558,357	97									532,492	32
33	Real Estate Taxes	(544)											(544)	33
34	Rent-Facility & Grounds		(1,080,000)	13,555									(1,066,445)	34
35	Rent-Equipment & Vehicles	(14,343)		14,734									391	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(10,160)	(133,185)	30,591									(112,754)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(900)											(900)	42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(900)											(900)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(181,221)	(132,199)	118,421									(194,999)	45

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,080,000	Salem Village Properties	100.00%	$	$ (1,080,000)	1
2	V	33	Real Estate Taxes	120,000	Salem Village Properties	100.00%		(120,000)	2
3	V	21	Bank Charges		Salem Village Properties	100.00%	625	625	3
4	V	30	Depreciation		Salem Village Properties	100.00%	388,458	388,458	4
5	V	32	Interest Expense		Salem Village Properties	100.00%	558,357	558,357	5
6	V	21	Replacement Taxes		Salem Village Properties	100.00%	361	361	6
7	V	33	Real Estate Taxes		Salem Village Properties	100.00%	120,000	120,000	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,200,000			$ 1,067,801	$ * (132,199)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. SAL.-NON OWNER	$	HEALTHCARE MNGMNT. ASSOC.	100.00%	$ 41,929	$ 41,929	15
16	V	19	PROFESSIONAL FEES		HEALTHCARE MNGMNT. ASSOC.	100.00%	11,594	11,594	16
17	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT. ASSOC.	100.00%	810	810	17
18	V	21	CLERICAL & GENERAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	78,462	78,462	18
19	V	24	SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	573	573	19
20	V	25	TRAVEL		HEALTHCARE MNGMNT. ASSOC.	100.00%	9,449	9,449	20
21	V	26	INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,615	1,615	21
22	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	11,391	11,391	22
23	V	30	DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,205	2,205	23
24	V	34	OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	13,555	13,555	24
25	V	32	INTEREST		HEALTHCARE MNGMNT. ASSOC.	100.00%	97	97	25
26	V	35	EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	14,734	14,734	26
27	V	10	NURSING SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	27,419	27,419	27
28	V	15	EMP. BEN. - HEALTH CARE		HEALTHCARE MNGMNT. ASSOC.	100.00%	3,180	3,180	28
29	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	46,504	46,504	29
30	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	5,470	5,470	30
31	V								31
32	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	9,214	9,214	32
33	V	17	ADMIN. SALARY - D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	20,443	20,443	33
34	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,287	1,287	34
35	V	27	EMP. BEN.-D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,504	2,504	35
36	V								36
37	V	17	MANAGEMENT FEE	184,014	HEALTHCARE MNGMNT. ASSOC.	100.00%		(184,014)	37
38	V								38
39	Total			$ 184,014			$ 302,435	$ * 118,421	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Suissa	Owner	Administrative	45.00	See Attached	13.41	20.63%	Salary	$ 9,214	17-7	1
2	Mark Suissa	Owner	Administrative		See Attached			Mgmt Fees	60,000	17-3	2
3	Eric Rothner	Relative	Administrative	0.00	See Attached	0.94	1.31%	Mgmt Fees	60,000	17-3	3
4	David Aryeh	Owner	Administrative	5.00	See Attached	25.96	36.06%	Salary	20,443	17-7	4
5	David Aryeh	Owner	Administrative		See Attached			Mgmt Fees	60,000	17-3	5
6	Lorraine Suissa	Relative	Administrative	0.00	None	40	100%	Salary	35,006	17-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 244,663		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HEALTHCARE MNGMNT. ASSOC.
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. SAL.-NON OWNER	ILL. & MO. PAT. DAYS	357,313	8	$ 187,631	$ 187,631	79,847	$ 41,929	1
2	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	357,313	8	51,885		79,847	11,594	2
3	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	357,313	8	3,624		79,847	810	3
4	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	357,313	8	351,114	271,845	79,847	78,462	4
5	24	SEMINAR	ILL. & MO. PAT. DAYS	357,313	8	2,566		79,847	573	5
6	25	TRAVEL	ILL. & MO. PAT. DAYS	357,313	8	42,286		79,847	9,449	6
7	26	INSURANCE	ILL. & MO. PAT. DAYS	357,313	8	7,228		79,847	1,615	7
8	27	EMPLOYEE BENEFITS	ILL. & MO. PAT. DAYS	357,313	8	50,973		79,847	11,391	8
9	30	DEPRECIATION	ILL. & MO. PAT. DAYS	357,313	8	9,866		79,847	2,205	9
10	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	357,313	8	60,660		79,847	13,555	10
11	32	INTEREST	ILL. & MO. PAT. DAYS	357,313	8	432		79,847	97	11
12	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	357,313	8	65,934		79,847	14,734	12
13	10	NURSING SALARIES	ILLINOIS PAT. DAYS	221,422	5	76,034	76,034	79,847	27,419	13
14	15	EMP. BEN. - HEALTH CARE	ILLINOIS PAT. DAYS	221,422	5	8,817		79,847	3,180	14
15	21	CLERICAL SALARIES	ILLINOIS PAT. DAYS	221,422	5	128,960	128,960	79,847	46,504	15
16	27	EMP. BEN. GEN. & ADMIN.	ILLINOIS PAT. DAYS	221,422	5	15,168		79,847	5,470	16
17										17
18	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED	60	8	41,231	41,231	13	9,214	18
19	17	ADMIN. SALARY - D. ARYEH	AVG. HOURS WORKED	72	5	56,690	56,690	26	20,443	19
20	27	EMP. BEN.-M. SUISSA	AVG. HOURS WORKED	60	8	5,760		13	1,287	20
21	27	EMP. BEN.-D. ARYEH	AVG. HOURS WORKED	72	5	6,943		26	2,504	21
22										22
23										23
24										24
25	TOTALS					$ 1,173,802	$ 762,391		$ 302,435	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. C # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	American National Bank		X	Mortgage	$62,203.00	8/31/98	$ 7,840,000	$ 7,420,225	8/31/05	7.30%	$ 558,357	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X	Working Capital - LOC		9/30/99		530,000	9/30/00		49,370	6
7												7
8												8
9	TOTAL Facility Related				$62,203.00		$ 7,840,000	$ 7,950,225			$ 607,727	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(25,865)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25,865)	14
15	TOTALS (line 9+line14)						$ 7,840,000	$ 7,950,225			$ 581,862	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CEN # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (25,962)	1
2	Allocated from HMA	X									97	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (25,865)	21

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	160,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	91,910	2
3. Under or (over) accrual (line 2 minus line 1).	$	(68,090)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	187,546	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	119,456	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999	91,910	12

Accrual of $187,546 is an estimate since there was no prior tax bill to determine accrual.

$544 of real estate tax paid in 2000 is for a non-care property.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 127,847 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 408,000	1
2					2
3	TOTALS			$ 408,000	3

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	272		1998	1976	$ 8,021,280	$ 205,674	20	$ 401,064	$ 195,390	$ 935,816	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPET			1998	16,898	433	20	845	412	1,760	9
10	CUBICLE CURTAINS			1998	16,514	423	20	826	403	1,859	10
11	WALLPAPER			1998	640	16	20	32	16	72	11
12	CORRIDOR VINYL			1998	4,124	106	20	206	100	464	12
13	WALLPAPER			1998	917	24	20	46	22	104	13
14	WALLPAPER			1998	628	16	20	31	15	70	14
15	WALLPAPER			1998	2,821	72	20	141	69	317	15
16	DOORS			1998	2,268	58	20	113	55	254	16
17	CHAIR RAILS			1998	558	14	20	28	14	65	17
18	WALLPAPER			1998	979	25	20	49	24	114	18
19	WALLPAPER			1998	717	18	20	36	18	84	19
20	WALLPAPER			1998	3,861	99	20	193	94	450	20
21	WALLPAPER			1998	872	22	20	44	22	103	21
22	WALLPAPER			1998	698	18	20	35	17	82	22
23	DTI INC			1998	13,394	343	20	670	327	1,452	23
24											24
25											25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				47,524	3,638		2,425	(1,213)	2,425	30
31	PAGE 12E TOTALS				145,253	2,112		4,121	2,009	4,121	31
32	PAGE 12D TOTALS				30,973	791		1,546	755	2,168	32
33	PAGE 12C TOTALS				38,786	1,159		1,968	809	3,095	33
34	PAGE 12B TOTALS				100,103	3,376		5,140	1,764	8,820	34
35	PAGE 12A TOTALS				113,788	4,743		5,690	947	11,105	35
36	TOTAL (lines 4 thru 35)				$ 8,563,596	$ 223,180		$ 425,249	$ 202,069	$ 974,800	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSES STATION			1998	1,564	40	20	78	38	176	9
10	ASPHALT WORK			1998	28,895	2,568	20	1,445	(1,123)	3,131	10
11	HAND RAILS			1998	10,182	261	20	509	248	1,188	11
12	CARPET			1998	1,090	28	20	55	27	124	12
13	FIRESTOPPING WORK			1998	895	23	20	45	22	98	13
14	DOOR HINGES &CLOSER			1999	930	24	20	47	23	82	14
15	WALLPAPER			1999	2,561	66	20	128	62	213	15
16	FIRE ALARM			1999	15,647	401	20	782	381	1,369	16
17	WALLPAPER			1999	981	25	20	49	24	94	17
18	CARPET			1999	1,258	32	20	63	31	116	18
19	FIRE ALARM REPAIRS			1999	663	17	20	33	16	66	19
20	PAINT & WALLPAPER			1999	29,300	751	20	1,465	714	2,930	20
21	MOTORS & FUSES			1999	1,100	28	20	55	27	110	21
22	ELECTRICAL WORK			1999	1,192	31	20	60	29	120	22
23	MISC PAINTING & DECO			1999	313	8	20	16	8	28	23
24	COVE BASES			1999	688	18	20	34	16	43	24
25	COVE BASES			1999	766	20	20	38	18	48	25
26	RAMP DOOR			1999	2,123	54	20	106	52	133	26
27	MISC PAINT & DEC			1999	666	17	20	33	16	36	27
28	WALLPAPER			1999	120	3	20	6	3	11	28
29	WALLPAPER			1999	247	6	20	12	6	20	29
30	ITEMS TO FIX HOLES			1999	1,262	32	20	63	31	110	30
31	PAINTING			1999	2,315	59	20	116	57	213	31
32	FILLING HOLES IN WAL			1999	548	14	20	27	13	47	32
33	BATHROOM REMODELING			1999	1,500	38	20	75	37	125	33
34	COVE BASE			1999	310	8	20	16	8	29	34
35	INSTALL DRAIN			1999	6,672	171	20	334	163	445	35
36	TOTAL (lines 4 thru 35)				$ 113,788	$ 4,743		$ 5,690	$ 947	$ 11,105	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPET			1999	1,926	49	20	96	47	176	9
10	A/C COMPRESSOR			1999	1,240	32	20	62	30	93	10
11	CARPET			1999	502	13	20	25	12	48	11
12	CARPENTRY &REMODELIN			1999	1,569	40	20	78	38	137	12
13	WALLPAPER			1999	167	4	20	8	4	14	13
14	FIRE DAMPERS			1999	58,800	1,508	20	2,940	1,432	5,145	14
15	WALLPAPER			1999	401	10	20	20	10	35	15
16	ELECTRICAL WORK			1999	942	24	20	47	23	78	16
17	DRYWALL AND PAINTING			1999	9,000	231	20	450	219	675	17
18	BATHROOM REMODELING			1999	517	13	20	26	13	39	18
19	ELECTRICAL WORK			1999	826	21	20	41	20	62	19
20	A/C MOTORS			1999	579	15	20	29	14	44	20
21	A/C PARTS			1999	662	17	20	33	16	52	21
22	WALLPAPER			1999	2,444	63	20	122	59	203	22
23	CARPENTRY & REMODEL			1999	765	20	20	38	18	63	23
24	MISC PAINTING & DECO			1999	343	9	20	17	8	30	24
25	TOILETS			1999	602	15	20	30	15	50	25
26	SIGNAGE			1999	874	280	20	87	(193)	138	26
27	FIRE ALARM REPAIRS			1999	515	13	20	26	13	46	27
28	PLUMBING			1999	2,350	60	20	118	58	197	28
29	SIGNAGE			1999	851	272	20	85	(187)	135	29
30	CARPENTRY & REMODEL			1999	2,300	59	20	115	56	192	30
31	MISC.PAINTING & DECO			1999	143	4	20	7	3	12	31
32	SIGNAGE			1999	1,025	328	20	103	(225)	172	32
33	MISC.PAINTING & DECO			1999	346	9	20	17	8	28	33
34	WALLPAPER INSTALL			1999	9,868	253	20	493	240	904	34
35	FIRE ALARM REPAIRS			1999	546	14	20	27	13	52	35
36	TOTAL (lines 4 thru 35)				$ 100,103	$ 3,376		$ 5,140	$ 1,764	$ 8,820	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR CLOSERS			1999	700	18	20	35	17	61	9
10	ECONOCARE			1999	981	25	20	49	24	94	10
11	MISC.PAINTING & DECO			1999	895	23	20	45	22	56	11
12	CARPET			1999	1,632	42	20	82	40	150	12
13	ELECTRICAL WORK			1999	665	17	20	33	16	41	13
14	PAINTING			1999	1,125	29	20	56	27	103	14
15	WALLPAPER			1999	700	18	20	35	17	64	15
16	SENSORS			1999	613	16	20	31	15	49	16
17	DRYWALL INSTALLATION			1999	4,000	103	20	200	97	367	17
18	CARPENTRY & REMODELI			1999	1,624	42	20	81	39	142	18
19	ELEVATOR REPAIRS			1999	954	24	20	48	24	76	19
20	CARPET			1999	526	13	20	26	13	41	20
21	FIRE ALARM REPAIRS			1999	2,017	52	20	101	49	160	21
22	DRYWALL SUPPLIES			1999	367	9	20	18	9	33	22
23	A/C COMPRESSOR			1999	1,240	32	20	62	30	98	23
24	PAINTING			1999	708	18	20	35	17	55	24
25	MISC PAINTING & DECO			1999	514	13	20	26	13	43	25
26	COVE BASES			1999	2,003	51	20	100	49	192	26
27	WALLPAPER			1999	1,952	50	20	98	48	180	27
28	BRICK WORK			1999	2,542	65	20	127	62	169	28
29	DOOR HARDWARE			1999	861	22	20	43	21	61	29
30	WALLPAPER			1999	470	12	20	24	12	34	30
31	PAINTING			1999	5,000	128	20	250	122	333	31
32	PAINTING			1999	4,000	103	20	200	97	267	32
33	PUMPS			1999	560	179	20	56	(123)	75	33
34	COVE BASE			1999	437	11	20	22	11	31	34
35	DECORATING			1999	1,700	44	20	85	41	120	35
36	TOTAL (lines 4 thru 35)				$ 38,786	$ 1,159		$ 1,968	$ 809	$ 3,095	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1999	3,903	100	20	195	95	260	9
10	WALLPAPER			1999	(7,068)	(181)	20	(353)	(172)	(471)	10
11	TILE			1999	506	13	20	25	12	29	11
12	PLUMBING WORK			1999	1,271	33	20	64	31	96	12
13	PAGING SYSTEM			1999	649	17	20	32	15	53	13
14	HVAC REPAIRS			1999	1,177	30	20	59	29	98	14
15	PAINTING AND DECOR			1999	860	22	20	43	21	72	15
16	LIGHT FIXTURES			1999	2,149	55	20	107	52	178	16
17	SEWER WORK			1999	1,249	32	20	62	30	83	17
18	CARPET			1999	408	10	20	20	10	22	18
19	TILE & COVE BASE			1999	1,373	35	20	69	34	81	19
20	PAINTING			1999	337	9	20	17	8	23	20
21	PAINT			1999	595	15	20	30	15	35	21
22	PLUMBING WORK			1999	902	23	20	45	22	53	22
23	FLOOR TILE			1999	900	23	20	45	22	60	23
24	TILE			1999	1,011	26	20	51	25	55	24
25	FLOOR WORK			1999	14,667	376	20	733	357	1,038	25
26	LIGHT FIXTURES			1999	546	14	20	27	13	29	26
27	FLOOR TILE			1999	626	16	20	31	15	34	27
28	PAINTING			1999	1,119	29	20	56	27	79	28
29	PAINTING			1999	630	16	20	32	16	43	29
30	BLINDS			1999	680	17	20	34	17	40	30
31	CUBICLE CURTAINS			1999	851	22	20	43	21	65	31
32	A.C PARTS			1999	594	15	20	30	15	43	32
33	EMERGENCY LIGHT			1999	613	16	20	31	15	52	33
34	WALL COVERING			2000	332	7	20	14	7	14	34
35	BORDER			2000	93	1	20	4	3	4	35
36	TOTAL (lines 4 thru 35)				$ 30,973	$ 791		$ 1,546	$ 755	$ 2,168	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL COVER			2000	301	6	20	11	5	11	9
10	BORDER			2000	172	3	20	6	3	6	10
11	WALLPAPER			2000	5,010	80	20	167	87	167	11
12	WALL COVERING			2000	1,361	19	20	40	21	40	12
13	WALLCOVER			2000	1,271	23	20	48	25	48	13
14	BORDER			2000	108	2	20	3	1	3	14
15	WALLPAPER			2000	3,712	44	20	93	49	93	15
16	WALL COVERING			2000	6,155	59	20	128	69	128	16
17	CUBICLE CURTAINS			2000	2,131	426	20	89	(337)	89	17
18	BORDER			2000	65	1	20	2	1	2	18
19	DRAPERIES			2000	553	111	20	5	(106)	5	19
20	BORDER			2000	340	4	20	9	5	9	20
21	BORDER			2000	97	1	20	2	1	2	21
22	BORDER			2000	2,058	20	20	43	23	43	22
23	VINYL FLOORING			2000	1,804	44	20	90	46	90	23
24	WALL COVERING			2000	535	5	20	11	6	11	24
25	ELECTRICAL WORK			2000	21,545	299	20	628	329	628	25
26	BORDER			2000	2,129	30	20	62	32	62	26
27	PAINT/WALLPAPER			2000	1,050	1	20	4	3	4	27
28	BORDER			2000	42		20	1	1	1	28
29	BORDER			2000	885	5	20	11	6	11	29
30	PAINTING			2000	41,550	133	20	346	213	346	30
31	UNDERLAYMENT			2000	275	6	20	13	7	13	31
32	DRYWALL/WALLPAPER			2000	575	4	20	10	6	10	32
33	OLYMPIAN GENERATOR			2000	41,977	762	20	1,574	812	1,574	33
34	CUBICLE CURTAINS			2000	8,390		20	677	677	677	34
35	DOORS			2000	1,162	24	20	48	24	48	35
36	TOTAL (lines 4 thru 35)				$ 145,253	$ 2,112		$ 4,121	$ 2,009	$ 4,121	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PHONE SYSTEM			2000	13,987	1,998	20	233	(1,765)	233	9
10	CUBICLE CURTAINS			2000	7,325		20	900	900	900	10
11	CUBICLE CURTAINS			2000	7,735		20	621	621	621	11
12	WALL SCONCE, CHANDELIER			2000	3,891		20	235	235	235	12
13	WALLCOVERING			2000	5,897	31	20	74	43	74	13
14	WALLPAPER			2000	717	14	20	30	16	30	14
15	WALLCOVERING			2000	7,972	1,595	20	332	(1,263)	332	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 47,524	$ 3,638		$ 2,425	$ (1,213)	$ 2,425	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SALEM VILLAGE NURSING & REHAB. CENTER, LLC
0044057
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Salem Village Nursing & Rehabilitation Center	312,261	84,367	29,691	(54,676)	59,334
Salem Village Properties	816,000	182,784	81,600	(101,184)	189,600
Health Management Associates	12,794	2,205	1,280	(925)	8,793
TOTALS	1,141,055	269,356	112,571	(156,785)	257,727
LINE 29: CURRENT YEAR					
Salem Village Nursing & Rehabilitation Center	62,177	17,627	3,032	(14,595)	3,032
Salem Village Properties					
Health Management Associates					
TOTALS	62,177	17,627	3,032	(14,595)	3,032
LINE 30: FULLY DEPRECIATED					
Salem Village Nursing & Rehabilitation Center					
Salem Village Properties					
Health Management Associates					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
Salem Village Nursing & Rehabilitation Center	374,438	101,994	32,723	(69,271)	62,366
Salem Village Properties	816,000	182,784	81,600	(101,184)	189,600
Health Management Associates	12,794	2,205	1,280	(925)	8,793
TOTALS	1,203,232	286,983	115,603	(171,380)	260,759

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CEN1# 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,141,055	$ 269,356	$ 112,571	$ (156,785)		$ 257,727	37
38	Current Year Purchases	62,177	17,627	3,032	(14,595)		3,032	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,203,232	$ 286,983	$ 115,603	$ (171,380)		$ 260,759	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 10,174,828	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 510,163	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 540,852	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 30,689	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,235,559	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		272		$			3
4	Additions	Allocated from HMA			13,555			4
5								5
6								6
7	TOTAL		272		$ 13,555 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 35,939 Description: See attached schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from HMA		$	$ 3,171	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,171	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 258,698	$		$ 258,698	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			47,278			47,278	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			199,504			199,504	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				241,595		241,595	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					136,665		136,665	13
14	TOTAL			$		$ 505,480	$ 378,260		$ 883,740	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Equipment Rental - Special Beds	31,185
2	Radiology	84,111
3	Lab	20,146
4	Oxygen Concentrators	1,223
5		
6		
7		
8		
9		
10		
		136,665

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,308,995	2,308,995	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	142,544	142,544	6
7	Other Prepaid Expenses	115,016	115,016	7
8	Accounts Receivable (owners or related parties)		(458,445)	8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,566,555	$ 2,108,110	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,000	13
14	Buildings, at Historical Cost		8,021,280	14
15	Leasehold Improvements, at Historical Cos	490,328	1,306,328	15
16	Equipment, at Historical Cost	426,421	426,421	16
17	Accumulated Depreciation (book methods)	(230,937)	(1,244,097)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 685,812	$ 8,917,932	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,252,367	$ 11,026,042	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,577,572	$ 1,637,356	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	467,767	467,767	28
29	Short-Term Notes Payable	530,000	530,000	29
30	Accrued Salaries Payable	227,387	227,387	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,535	23,535	31
32	Accrued Real Estate Taxes(Sch.IX-B)	187,546	187,546	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	120,000	120,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,133,807	$ 3,193,591	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,420,225	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,420,225	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,133,807	$ 10,613,816	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 118,560	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,252,367	$ #REF!	48

*(See instructions.)

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LI# 0044057 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		
Accrued Management Fees	120,000	120,000
	120,000	120,000

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,112,834	1	
2	Restatements (describe):		2	
3	**Schedule attached**	(322,615)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 790,219	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(671,659)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (671,659)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 118,560	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	SALEM VILLAGE NURSING & REHA #	0044057	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		790,219
Adjustments:		
		-
		-
		-
1998 Medicare Rate Adjustment		315,693
Office Expense Adjustment		6,922
Total adjustments		322,615
Balance - Beginning of Year		1,112,834
Equity(Deficit) from Page 17 Col 1		118,560
Related Party		
Equity(Deficit)	161468	
Income	132199	
		293,667
Combined Equity - End of Year		412,227

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTI # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,454,799	1
2	Discounts and Allowances for all Levels	(1,279,058)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,175,741	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	913,945	6
7	Oxygen	2,317	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 916,262	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	900	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	337,623	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,289	19
20	Radiology and X-Ray	192,012	20
21	Other Medical Services	20,670	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 571,494	23
	D. Non-Operating Revenue		
24	Contributions	3,051	24
25	Interest and Other Investment Income***	25,962	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,013	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,692,510	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,710,068	31
32	Health Care	4,285,861	32
33	General Administration	1,929,978	33
	B. Capital Expense		
34	Ownership	1,407,589	34
	C. Ancillary Expense		
35	Special Cost Centers	883,740	35
36	Provider Participation Fee	146,933	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,364,169	40
41	**Income before Income Taxes (line 30 minus line 40)****	(671,659)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (671,659)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SALEM VILLAGE NURSING & RE # 0044057 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,205	2,250	$ 48,582	$ 21.59	1
2	Assistant Director of Nursing	2,027	2,108	47,243	22.41	2
3	Registered Nurses	41,738	42,619	856,104	20.09	3
4	Licensed Practical Nurses	49,851	50,901	861,535	16.93	4
5	Nurse Aides & Orderlies	134,939	137,499	1,246,779	9.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,803	12,043	116,343	9.66	8
9	Activity Director	4,597	4,696	57,007	12.14	9
10	Activity Assistants	18,246	18,463	148,815	8.06	10
11	Social Service Workers	11,530	11,765	173,066	14.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,549	43,417	356,933	8.22	15
16	Dishwashers					16
17	Maintenance Workers	14,354	14,647	155,316	10.60	17
18	Housekeepers	38,702	39,491	288,915	7.32	18
19	Laundry	15,789	16,111	108,103	6.71	19
20	Administrator	2,153	2,197	72,587	33.04	20
21	Assistant Administrator					21
22	Other Administrative	2,038	2,080	35,006	16.83	22
23	Office Manager					23
24	Clerical	16,486	16,822	170,084	10.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,136	2,179	19,785	9.08	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	411,143	419,288	$ 4,762,203 *	$ 11.36	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	662	$ 16,533	1-3	35
36	Medical Director	Monthly	30,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	612	26,973	10-3	38
39	Pharmacist Consultant	Monthly	5,712	10-3	39
40	Physical Therapy Consultant	300	9,533	10a-3	40
41	Occupational Therapy Consultant	484	14,513	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	269	4,891	11-3	44
45	Social Service Consultant				45
46	Other(specify) Psycho-Social	347	12,157	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,674	$ 120,312		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	19	$ 608	10-3	50
51	Licensed Practical Nurses	47	5,204	10-3	51
52	Nurse Aides	1,220	29,128	10-3	52
53	TOTAL (lines 50 - 52)	1,286	$ 34,940		53

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENT # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Patty (01/01/00 - 08/16/00)	Administrator	None	$ 43,333
C. Valera (08/17/00-12/31/00)	Administrator	None	29,253
Lorraine Suissa	Adminstrative	None	35,006
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,592

B. Administrative - Other

Description	Amount
Mark Suissa - Management Fees	$ 60,000
Eric Rothner - Management Fees	60,000
David Aryeh - Management Fees	60,000
Healthcare Management Associates - Bookkeeping Services	184,014
TOTAL (agree to Schedule V, line 17, col. 3)	$ 364,014
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Heckscher	Legal	$ 26,061
Lawrence Schwartz	Legal	5,880
Frost, Ruttenberg & Rothblatt	Accounting	40,802
Ceridian Employer Service	Data Processing	7,302
American Data	Data Processing	2,400
Care Computer Systems	Data Processing	3,570
Keith Kalkenborn	Data Processing	250
Computer Renaissance	Data Processing	3,866
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 90,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,557
Unemployment Compensation Insurance	93,352
FICA Taxes	356,118
Employee Health Insurance	172,841
Employee Meals	5,161
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	3,460
Employee Welfare	14,652
TOTAL (agree to Schedule V, line 22, col.8)	$ 759,141

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,552
(Indicate # of checks performed 130)	
Classified Advertising	11,240
Advertising & Promotion	13,167
Allocated from HMA	810
Yellow Page Advertising	756
Less: Public Relations Expense	( )
Non-allowable advertising	(13,167)
Yellow page advertising	(756)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,602

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,533
Allocated from HMA	573
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,106

**See instructions.

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LL(# 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SALEM VILLAGE NURSING & REHAB. CENTER, LLC # 0044057 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,929** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **146,034**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **5,161** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw